

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN7105	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  06/17/2010
NAME OF PROVIDER OR SUPPLIER  BETHESDA HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 444 ONE ELEVEN PLACE COOKEVILLE, TN 38501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments  An annual Licensure survey and Complaint investigation #'s 23170 and 25680, were completed on June 15-17, 2010, at Bethesda Health Care Center. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6200

10J811

TITLE

Regional Administrator

(X6) DATE

6.30.10

If continuation sheet 1 of 1

JUL 01 2010